

# Basketball Clinic Registration Form

Please complete form and scan/e-mail to Tom Schulte (Schulte.tom@gmail.com) or mail to: 12655 E. Austin Rd, Manchester, MI 48158

Athlete's First name \_\_\_\_\_ Last Name \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Disability \_\_\_\_\_

Description of Impairment (Level of injury, movement limitations, cognitive or sensory involvement)

\_\_\_\_\_

Do you use a wheelchair \_\_\_\_\_ Crutches \_\_\_\_\_ Walker \_\_\_\_\_

Do you own a sport wheelchair used for basketball? (circle one) Yes No

Any other information you would like to share \_\_\_\_\_

What is your level of experience or number of years playing Wheelchair Basketball?

None, First time!  Beginner, 1-2years experience  Intermediate 3-5years  Advanced 5yrs+

If you play for a team, what is the team name / coach? \_\_\_\_\_

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If you have questions about our clinic or have concerns as to how or whether a participant would be able to participate please contact Tom Schulte (our registration coordinator) below:

**Tom Schulte**  
Registration Coordinator  
734-355-2463  
Schulte.tom@gmail.com

**Paul Schulte**  
President, Paul Schulte Foundation  
Paralympian, Instructor for Clinic  
pschulte14@gmail.com